

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1780

01281

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19 48

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive as

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

Address

DURATION

7 days

unknown

Date of

(City or town)

(County)

(State)

at home

Injured at work?

no

defective Keenie Stone

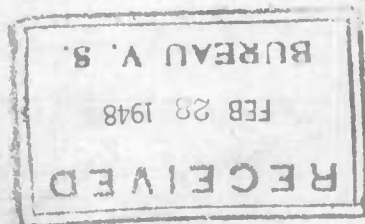
John M. Caffey M.D.

M. D. or

Annapolis, Maryland

Date signed

2-23-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01282

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 809 West Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ida Mackinn Rhein

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Joseph Abern

## 7. Birth date of

deceased (mo., day, yr.)

Jan 28 1882

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

66

hrs.

min.

## 9. Birthplace

Annapolis, AACo., Md.  
(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business

## FATHER

## 12. Name

Isaac Mackinn

## 13. Birthplace

England

## MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

Lamorne Chow

## Address

809 West St. Annapolis

## 17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

2/23/48  
(month) (day) (year)

## Cemetery or crematory

St. Ann's Cemetery

## Location

Annapolis, Md.

## 18. Funeral director

John M. Taylor, Inc.

## Address

Annapolis, Md.

## 19.

Feb. 23 48

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 19 48 at 9:2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 16 19 48 to Feb 21 19 48and that I last saw him alive on Feb 21 19 48

## Immediate cause of death

Coronary Thrombosis

## DURATION

SuddenDue to Myocardial acutecoronaryDue to MyocardialinfarctionOther conditions Arteriosclerosisarteriosclerosis

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

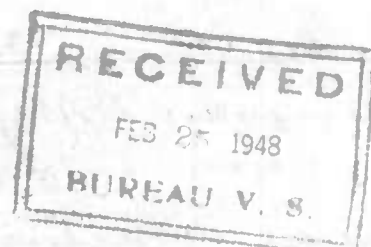
23. SIGNATURE George C. Boyd M. D. or otherAddress Annapolis, Md. Date signed 2-23-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01284

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County... A. A.

City or town... Marley Creek  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Point Pleasant

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... A. A.

City or town... Marley Creek  
(If outside city or town limits, write RURAL and give nearest town)

Street No... Point Pleasant  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Henry W. Becker

### 3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widower

6.(b) Name of husband or wife... late Kunniqunda

7. Birth date of

deceased (mo., day, yr.)

May 28, 1868

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

79

8

13

hrs.

min.

9. Birthplace

Baltimore Md  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Shoe maker

FATHER

12. Name

August Becker

13. Birthplace

Germany

MOTHER

14. Maiden name

Unknown

15. Birthplace

Germany

16. Informant

August Becker

Address

Point Pleasant, Marley Creek

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2.14.48

Cemetery or crematory

New Cathedral

Location

3900 Old Frederick Rd

18. Funeral director

Wm. H. Witzke

Address

4101 Edmondson Ave

19. Aug 13 19 48

(Date rec'd by registrar)

H. W. Witzke

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 11 19 48 at 9.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 48 to Feb 11 19 48

and that I last saw him alive on Feb 11 19 48

Immediate cause of death... Cerebral Lobar Hemorrhage

DURATION

2 days

Due to.....

Due to.....

Other conditions.....

Senile Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... Marley Creek Feb 11-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01285

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Fort George G. Meade  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

Seaton Hospital 1-7. Kemp G. Meade.How long in hospital or institution? 5 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Severn  
(If outside city or town limits, write RURAL and give nearest town)Street No. Monard, Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

George F. Blais Jr.

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

August - 30 - 1947

## 8. AGE:

Years

Months

Days

If less than one day

61

hrs.

min.

## 9. Birthplace

Emergency Hosp. Annapolis, Md.  
(Town, county, and state)

## 10. Usual occupation

Travel

## 11. Industry or business

## FATHER

## 12. Name

George F. Blais Jr.

## 13. Birthplace

Portland, Oregon

## MOTHER

## 14. Maiden name

Catherine Marion Styk

## 15. Birthplace

Baltimore, Md.

## 16. Informant

George F. Blais Jr. (Father)

## Address

Severn, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Mar 10 1948  
(month) (day) (year)

## Cemetery or crematory

Glenhaven

## Location

Ritchie Highway

## 18. Funeral director

Leo S. Cook

## Address

1701-03 N. Patterson Park Ave

## 19. 3/4

(Date rec'd by registrar)

19

A. W. Hahn

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 28-February 1948 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

Acute bronchopneumonia infectious

## DURATION

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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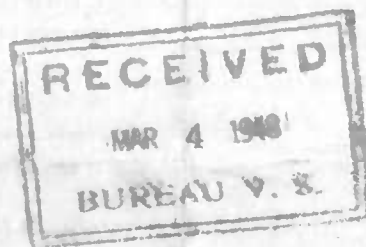
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*Elm Pa. 1st H. House*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

01286

Reg. Dist. No. 28

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years, 8 months, 19 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital, Crownsville, Md.  
 How long in hospital or institution? 35 years, 8 months, 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town West Roland Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4656 Falls Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOSEPH W. BROWN (WINSLOW)

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro B. (a) Single, married, widowed, or divorced Married  
 B. (b) Name of husband or wife unknown  
 7. Birth date of deceased (mo., day, yr.) unknown  
 8. AGE: Years' 77 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Junk Dealer  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name unknown  
 13. Birthplace \_\_\_\_\_  
 MOTHER 14. Maiden name unknown  
 15. Birthplace \_\_\_\_\_

16. Informant Hospital Records  
 Address Crownsville, Maryland  
 17. Burial Date thereof 2-12-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
Int. Chas. Auburn  
 Cemetery or crematory St. John's, Auburn  
 Location Mrs. Saml. H. Hensley  
 18. Funeral director Mrs. Saml. H. Hensley  
 Address 578 W. Biddle St. Balto.  
 19. Feb 10 48 E. Joyce Loebe  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 10th 1948 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
October 1941 to February 10 1948  
 and that I last saw him alive on February 10th 1948

Immediate cause of death Chronic Myocarditis  
 DURATION 1 year  
 Due to Manic Depressive Psychosis Known to us since 5/22/1912

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Jacob H. Hensley M.D. M. D. or other \_\_\_\_\_  
 Address Crownsville, Maryland Date signed 2/10/48

RECEIVED

FEB 12 1948

BUREAU V.A.

P. 1.  
Richardson

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93a

01287

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
City or town Spa Road, Annapolis Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

817 Spa Road

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Chambers

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1891

6. (c) If alive, give age..... years

8. AGE:

57

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Annapolis neck, A. G. Co. Md  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

Isaac Chambers

13. Birthplace

A. G. Co. Md.

14. Maiden name

Sophia Chew

15. Birthplace

A. G. Co. Md

16. Informant

Bertha Johnson

Address

11 Greenfield St. Annapolis Md

17.

Burial

Date thereof

Feb 7, 1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Brewer Hill

Location

Annapolis, Md.

18. Funeral director

J. B. Johnson

Address

Annapolis Md. P. O. Box 462

19.

Feb. 6

19

48

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Anne Arundel

City or town

Spa Road, Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

817 Spa Road

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

February 7

19

48 at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 6

19

48

to

Feb 7

19

48

and that I last saw him

alive on

Feb 7

19

48

19

48

Immediate cause of death

Renal Myocarditis

DURATION

4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. Johnson

M. D. or other

Address

Annapolis, Md.

Date signed

2/5/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 7 1948  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182

012882

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

### 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Jessups  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 weeks  
 Hospital, institution, or street address where death occurred:  
Route 175  
 How long in hospital or institution? .....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State ..... County .....  
 City or town .....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war .....

### 3. (a) FULL NAME

Mary Patricia Cooley

### 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) Dec. 24 - 1947 6. (c) If alive, give age ..... years

8. AGE: Years Months Days If less than one day  
2 1 ..... hrs. .... min.

9. Birthplace Beland Memorial Hosp. - Riverdale, Md.  
 (Town, county, and state)

10. Usual occupation none

11. Industry or business .....

12. Name John Douglas Cooley

13. Birthplace Jessups, Md.

14. Maiden name Karel E. Ruppert

15. Birthplace Jessups, Md.

16. Informant John D. Cooley (father)

Address Jessups, Md.

17. Burial Date thereof Feb. 28, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Savage

Location Savage, Md.

18. Funeral director William H. Houlston

Address Laurel, Md.

19. Feb 26 4-8 Clara Cooley  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 19 48 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19....., to ..... 19.....  
 and that I last saw him ..... alive on ..... 19.....

Immediate cause of death Asphyxiation

Due to Was put in crib with twin sister after being given her formula, and about 2 hrs. later was found dead. She was blue in the face.  
 Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE Kustad & Paubert Ltd.

Address Blues Avenue, Md. Date signed 2/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 6 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0128922

## 1. PLACE OF DEATH:

County ANNE ARUNDELCity or town LAUREL, MD - RURAL  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yearsHospital, institution, or street address where death occurred:  
DISTRICT TRAINING SCHOOLHow long in hospital or institution? 20 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ANNE ARUNDELCity or town LAUREL, MD - Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

THELMA COXSON

## 3.(b) Social Security Number

4. Sex

F

5. Color or race

C

6.(a) Single, married, widowed, or divorced

S6.(b) Name of husband or wife NONE7. Birth date of deceased (mo., day, yr.) APRIL 20 1915  
6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 32 Months 9 Days 22  
If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace WASH., D.C.  
(Town, county, and state)10. Usual occupation NONE11. Industry or business NONE12. Name ORION WHITING13. Birthplace ?14. Maiden name SARAH COXSON15. Birthplace WASH., D.C.16. Informant HISTORY of DIST. TRAINING SCHOOLAddress LAUREL, MD.17. Removal Date thereof 2-13-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Closh. DC.Location Joseph Jennifer18. Funeral director Joseph JenniferAddress 1146 2nd St. Wash. DC19. 2-13 19 48 Blaise Housh  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1948 at 10 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 1946 to FEB 12 1948  
and that I last saw her alive on FEB 12 1948Immediate cause of death CANCER OF BREAST  
E METASTASIS

DURATION

10-12 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Mental Deficiency - Embolus

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. D. Skiff MD

M. D. or other

Address Laurel, MD Date signed Feb, 48

RECEIVED

APR 6 1948

BUREAU V. D.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01290  
Reg. Dist. No. 2)

### 1. PLACE OF DEATH:

County Anne Arundel Co.  
City or town Emergency Hospital, Annapolis.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2-13-48 - 2-19-48.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution? 2-13-48 - 2-19-48.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Anne Arundel  
City or town Fothian  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

John Creek

### 3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced

### 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 1 1884 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 63 Months 7 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Durham, Md.  
(Town, county, and state)

10. Usual occupation Road side market

11. Industry or business

12. Name Joseph Creek and  
13. Birthplace Dianna Ringer  
14. Maiden name Mary Moulton  
15. Birthplace Fothian

16. Informant Funeral  
Address Adams Ave

17. (Burial, cremation, or removal. Which?) Burial Date thereof Feb 22 48  
(month) (day) (year)

Cemetery or crematory Adams Ave  
Location Fothian, Md.

18. Funeral director J. A. Sandridge, Inc.  
Address Stilesville, Md.

19. Feb. 20 48  
(Date rec'd by registrar) Registrar J. A. Sandridge

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 - 1948, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 to Feb. 18 1948  
and that I last saw him alive on Feb. 18 - 1948

Immediate cause of death Cornary thrombosis  
Due to gangrene of left foot  
Due to endarteritis obliterans  
Other conditions endarteritis obliterans  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Emily H. Wilson, M.D.  
Address Fothian, Md. Date signed 2-20-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **01291**

### 1. PLACE OF DEATH:

County... **Anne Arundel**  
 City or town... **Crownsville, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **1 year, 8 months, 4 days**  
 Hospital, institution, or street address where death occurred:  
**Crownsville State Hospital, Crownsville, Md.**  
 How long in hospital or institution? **1 year, 8 months, 4 days**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... **Maryland** County...  
 City or town... **Baltimore**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **627 Vine**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... ☒

### 3. (a) FULL NAME

**ALICE DAVIDSON**

### 3. (b) Social Security Number

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, married, widowed, or divorced **Married**  
 6. (b) Name of husband or wife **Unknown to us**  
 7. Birth date of deceased (mo., day, yr.) **Unknown**  
 8. AGE: Years **60** Months **?** Days **?** If less than one day **hrs. min.**

9. Birthplace **Unknown**  
 (Town, county, and state)  
 10. Usual occupation **Unknown**  
 11. Industry or business  
 12. Name **Unknown**  
 13. Birthplace  
 14. Maiden name **Unknown**  
 15. Birthplace

16. Informant **Hospital Records**  
 Address **Crownsville, Maryland**  
 17. **Burial** Date thereof **2/16/48**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or **Hospital**  
 Location **Crownsville, Md.**  
 18. Funeral director **Sup. of Hospital**  
 Address **Crownsville, Md.**  
 19. **2/16** **48** **E7 Joyce Local**  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH **February 5th** 19. **48** at **7:00 P.M.**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**June 1st** 19. **46** to **February 5th** 19. **48**  
 and that I last saw her alive on **February 5th** 19. **48**  
 Immediate cause of death **General Arteriosclerosis** Known to us  
**since 6/1/1946**  
 Due to...  
 Due to...  
 Other conditions **Psychosis With Cerebral** Known to u  
**Arteriosclerosis- Right Hemiplegia** since  
 (Include pregnancy within 3 months of death) **6/1/46**  
 Major findings of operations...  
 Date of op...  
 Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE **Jacob Hangersten M.D.**  
 Address **Crownsville, Maryland** Date signed **2/6/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

*Justine Thorne*





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01292

Reg. Dist. No. 20

## 1. PLACE OF DEATH:

County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. Female  
Colored  
Married  
Charles Davis

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Watch?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by Registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19.. at ..

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1-24 19.. to 2-25 19..  
and that I last saw him alive on 2-24 19..

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01293

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County a. a. CoCity or town ANNAPOLIS  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 YRSHospital, institution, or street address where death occurred:  
119 West St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ANCity or town ANNAPOLIS  
(If outside city or town limits, write RURAL and give nearest town)Street No. 119 WEST ST.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MILTON M. DAWSON

## 3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife EFFIE Dawson6. (c) If alive, give age 66 years7. Birth date of deceased (mo., day, yr.) JULY 22 1871

8. AGE: Years Months Days If less than one day

7672hrs.min.9. Birthplace SHENANDOAH VIRGINIA  
(Town, county, and state)10. Usual occupation CABINET MAKER.11. Industry or business SELF12. Name ISAAC DAWSON13. Birthplace VIRGINIA14. Maiden name SARAH WEAVER15. Birthplace VIRGINIA16. Informant EFFIE DAWSONAddress 119 WEST STREET ANNAPOLIS MD.17. Burial Date thereof 2/27/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Moreland ParkLocation Balto. Md.18. Funeral director William Cook Inc.Address 1217 St. Paul St.19. 2/26 19 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 19 48 at 1230 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 21 19 48 to Feb 24 19 48and that I last saw him alive on Feb 24 19 48

Immediate cause of death

DURATION

Carcinoma of Stomach ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. F. Klawans, M.D.Address Annapolis, Md Date signed 2/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01294

Reg. Dist. No. 23

<b>1. PLACE OF DEATH:</b> County..... <u>Anne Arundel</u> City or town..... <u>Glen Burnie</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>6 weeks</u> Hospital, institution, or street address where death occurred:  How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Anne Arundel</u> City or town..... <u>Glen Burnie</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>443 Crain Highway N.E.</u> (If rural, give LOCATION) <u>NO.</u> 2. (a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Daniel R. Dengley</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>white</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widower</u>		<b>MEDICAL CERTIFICATION</b>	
<b>B. (b) Name of husband or wife</b> <u>Annie Dengley</u>		<b>B. (c) If alive, give age</b> ..... <u>✓</u> ..... years		<b>20. DATE OF DEATH</b> ..... <u>February 21</u> ..... 19 <u>48</u> ..... at <u>8:10</u> <u>AM</u>		<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Feb. 21</u> ..... 19 <u>48</u> ..... to <u>Feb. 21</u> ..... 19 <u>48</u> .....	
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>January 4, 1873</u>		<b>8. AGE:</b> Years..... <u>75</u> ..... Months..... <u>1</u> ..... Days..... <u>17</u> ..... If less than one day..... hrs. .... min.		and that I last saw h..... alive on..... <u>Feb. 21</u> ..... 19 <u>48</u> .....		<b>Immediate cause of death</b> <u>Cerebral Hemorrhage</u>	
<b>9. Birthplace</b> <u>Boyetown, Pa.</u> (Town, county, and state)		<b>10. Usual occupation</b> <u>Hospital Attendant - Retired</u>		<b>Due to</b> <u>Cadio - Vascular Disease</u>		<b>DURATION</b> <u>10 days</u>	
<b>11. Industry or business</b>		<b>12. Name</b> <u>Henry Dengley</u>		<b>Other conditions</b> (Include pregnancy within 3 months of death)		<b>Major findings of operations</b> Date of op.....	
<b>13. Birthplace</b> <u>Boyetown, Pa.</u>		<b>14. Maiden name</b> <u>Theresa Doghy</u>		<b>Antopsy results</b> <b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.		<b>22. VIOLENCE:</b> If death was due to external cause, fill in the following:	
<b>15. Birthplace</b> <u>Boyetown, Pa.</u>		<b>16. Informant</b> <u>Mrs. Florence Ains</u>		<b>Where did injury occur?</b> (City or town)..... (County)..... (State).....		<b>Injured at home, farm, industry, public place (where?)</b> Means of injury..... Injured at work?.....	
<b>17. (Burial, cremation, or removal, which?)</b> <u>Burial</u>		<b>Date thereof</b> <u>Feb. 23, 1948</u> (month)-(day)-(year)		<b>Injured at home, farm, industry, public place (where?)</b> Means of injury..... Injured at work?.....		<b>23. SIGNATURE</b> <u>James S. Billings</u> ..... M. D. or other <u>Glen Burnie, Md.</u> ..... Date signed..... <u>Feb. 21, 1948</u>	
<b>Cemetery or crematory</b> <u>Cedar Hill</u>		<b>Location</b> <u>Brooklyn, Md. R.F.D.</u>		<b>18. Funeral director</b> <u>Thomas W. Singleton</u>		<b>Address</b> <u>Glen Burnie, Md.</u>	
<b>19. (Date rec'd by registrar)</b> <u>2/23</u> ..... 19 <u>48</u> .....		<b>Registrar</b> <u>L. J. [Signature]</u>		<b>Address</b> <u>Glen Burnie, Md.</u>		<b>Date signed</b> <u>Feb. 21, 1948</u>	

RECEIVED

FEB 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3 days

## 3. (a) FULL NAME

JULIE NICOLAI DICKHOFF

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Hugo Dickhoff6. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.)

Jan. 2, 1882

8. AGE:

Years

Months

Days

If less than one day

66124

hrs.

min.

9. Birthplace

Howard County, Maryland  
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

FATHER

12. Name

August Nicolai

13. Birthplace

Germany

MOTHER

14. Maiden name

Wehland

15. Birthplace

Maryland

16. Informant

Mr. Hugo Dickhoff

Address

Fairfax Road, Annapolis, Maryland

17.

Cremation

Date thereof

2-28-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Ft. Lincoln Cemetery

Location

Washington, D.C.

18. Funeral director

Ben L. Hopping and Son

Address

170-172 West St. Annapolis, Md.

19.

Feb 28 19 48

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Rural Nr Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. RFD Annapolis  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 19 48 at 1 40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 20 19 48 to Feb 26 19 48and that I last saw him alive on Feb 26 19 48

Immediate cause of death

Myocarditis + Myocardial Infarction (Ch)

Due to

Arteriosclerosis

Due to

Other conditions

Ch. Intermit. Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Bond

M. D. or other

Address

Annapolis MdDate signed 2-27-48



RECEIVED

MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01296

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Heaven Grove  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

RAYMOND LEE FIFER

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 21<sup>st</sup> 1947

8. AGE:

Years

Months

Days

If less than one day

092

hrs.

min.

9. Birthplace Annapolis, A.A. Co., Md.  
(Town, county, and state)10. Usual occupation none11. Industry or business —

FATHER

12. Name

Norman C. Fifer

13. Birthplace

Baltimore Md.

MOTHER

14. Maiden name

Mildred Magruder

15. Birthplace

Washington, D. C.

16. Informant

Mr. Norman C. Fifer

Address

Seven Grove, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Baltimore Cemetery

Location

Baltimore Md.

18. Funeral director

John H. Taylor & Son

Address

Annapolis, Maryland

19.

(Date rec'd by registrar)

19

48

19

Feb. 25

19

48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 19 48 at 9:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 21 19 47 to June 23 19 48and that I last saw him alive on Feb 23 19 48

Immediate cause of death

acute tracheo bronch. inf.

DURATION

3 days.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions

erythroblastosisfoetalis  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_

Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

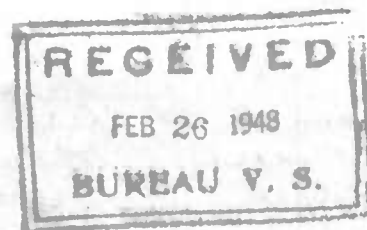
23. SIGNATURE

S. Borsuch M.D.

M. D. or other

Address

Annapolis MdDate signed 2/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

01297

## 1. PLACE OF DEATH:

County Anne Arundel Co  
 City or town Brocklyn Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred:  
231 Townsend Ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Anne Arundel  
 City or town Brocklyn Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 231 Townsend Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Harry Ford

## 3. (b) Social Security Number

215-03-0270

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 8. (b) Name of husband or wife Mary E. Ford  
 7. Birth date of deceased (mo., day, yr.) Aug 2, 1878 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 68 Months 6 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Balto Md  
 (Town, county, and state)  
 10. Usual occupation Sheet Metal employee  
 11. Industry or business retired  
 12. Name William E Ford  
 13. Birthplace Balto Md  
 14. Maiden name Laura  
 15. Birthplace Md

16. Informant Mrs Esther V. Kutzley  
 Address 231 Townsend Ave  
 17. Burial Date thereof Feb 10, 1948  
 (Burial, cremation, or removal) (Which?) (month) (day) (year)  
 Cemetery or crematory Grav. Olives  
 Location Balto Md  
 18. Funeral director A. Donald Evans  
 Address 1400 S Charles St  
 19. 2/7/48 19 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1948 at 1:45 P. M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 1945 to Feb 7 1948  
 and that I last saw him alive on 2/6/48 1948

Immediate cause of death Coronary thrombosis DURATION \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions arteriosclerosis  
Hypertension  
Cerebral embolism  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Samuel R. B. M. D. or other \_\_\_\_\_  
 Address 203 Calapoco St Date signed 2/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age shown on:

FILM No. G 114 APR 1 1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

01298

Reg. Dist. No. 48

### 1. PLACE OF DEATH:

County Anne Arundel

City or town Ferndale  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Rural - Ferndale  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 320 Broad View Blvd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Washington U. G. Franklin

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Anna L. Franklin

7. Birth date of deceased (mo., day, yr.) March 7, 1864 6. (c) If alive, give age 84 years

8. AGE: Years 83 Months 84 Days 11 If less than one day 7 hrs. min.

9. Birthplace Baltimore Md.  
(Town, county and state)

10. Usual occupation Contractor

11. Industry or business Retired

12. Name George Franklin

13. Birthplace England

14. Maiden name Louise Unknown

15. Birthplace Unknown

16. Informant Agnes Franklin

Address 320 Broad View Blvd.

17. Burial Date thereof 2-17-48  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Green Haven

Location Pitcher Highway

18. Funeral director Wm. Cook Inc.

Address 1217 St. Paul St.

19. 2-16-48 D. W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1948 at 1:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Feb. 14, 1948 and that I last saw him alive on Feb. 13, 1948

Immediate cause of death Coronary Vascular Disease DURATION 2 years

Due to Same

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Enlarged Prostate

Date of op. Sept. 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James S. Beckwith M.D. M. D. or other Edna Burns M.D. Address Feb 15, 1948

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01299

932

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Joyace Lane  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Joyace Station  
(If outside city or town limits, write RURAL and give nearest town)Street No. Joyace Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Lavilla Ann Gold

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Dr Edwin Thomas Gold

7. Birth date of deceased (mo., day, yr.)

Nov 12 1851

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

9622

hrs.

min.

9. Birthplace

Augusta Co. Va.  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Abraham Kibler

13. Birthplace

Va.

MOTHER

14. Maiden name

Marion Redmon

15. Birthplace

Va.

16. Informant

Mrs Mary Gold Carter

Address

Joyace Lane A & Co Md.

17. (Burial, cremation, or removal, Which?)

Date thereof

July 5 1948  
(month) (day) (year)

Cemetery or crematory

Riverview Cemetery

Location

Richmond Va

18. Funeral director

Address

John W. Taylor, SonAnnapolis Md.

19. (Date rec'd by registrar)

Feb 3 1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 19 48 at 4:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 19 48 to Feb 3 19 48and that I last saw him alive on Feb 3 19 48

Immediate cause of death

Myocarditis + Myocardial  
infarction

DURATION

2 weeks

Due to

Due to

Other conditions

Arteriosclerosisunknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Beal

M. D. or other

Address

Annapolis MdDate signed 2.3.48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. It is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
FEB 6 1948  
BUREAU V M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

01300

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel

City or town Parole  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan. 30, 1948

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

Annapolis, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1948 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on Jan. 30, 1948 to Feb 9, 1948

Immediate cause of death Pneumonia

Other conditions Premature Baby

Major findings of operations 8 mos. gestation  
(Include pregnancy within 3 months of death)

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

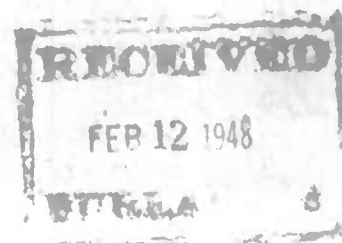
DURATION

2 days

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

Register

01301

1. PLACE OF DEATH:

(a) Baltimore City, Maryland  
 (b) Street address 143 Meadow Road  
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County  
 (c) City or town Baltimore  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 421 N. Bouldin St.  
 (If rural give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yea, name country

3 (a) FULL NAME

EDITH RACHEL GRAULING

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. none

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or divorced

married

6 (b) Name of husband or wife Frederick Grauling

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Dec. 2. 1895

8. AGE:

Years

Months

Days

If less than one day

52

2

6

hr.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Harrison H. Smith

13. Birthplace Baltimore

14. Maiden Name Mary Hugbus

15. Birthplace Baltimore

16 (a) Informant Mr. Frederick Grauling

(b) Address 421 N. Bouldin St.

17 (a) Burial

(b) Date thereof Feb. 12. 1948

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address Baltimore Md.

19 (a) 0 1948

(Date rec'd by registrar)

Wilmington, Delaware

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8. 1948 at 3.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6. 1947 to Feb 8. 1948 and that I last saw him alive on Feb 8. 1948.

Immediate cause of death

carditis (rheumatic)

Duration

?

Due to

rheumatic fever

?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. C. Sobhial

Address 447 H. Kenwood Ave Date signed Feb 8. 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01302

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 121 Conduit St.  
Hospital, institution, or street address where death occurred: Annapolis Hospital  
How long in hospital or institution? 121 Conduit St.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
State Maryland County Anne Arundel  
City or town 121 Conduit St.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Annapolis Md.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Anne L. Gray

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
6.(b) Name of husband or wife Clinton B. Gray  
7. Birth date of deceased (mo., day, yr.) Aug 8<sup>th</sup> 1871 8.(c) If alive, give age 76 years  
8. AGE: Years 76 Months 6 Days 14 It less than one day hrs. min.  
9. Birthplace West Va.  
(Town, county, and state)  
10. Usual occupation None

### 11. Industry or business

12. Name Patrick M. Hale  
13. Birthplace Ireland  
14. Maiden name Mary Fahey  
15. Birthplace Ireland

16. Informant Mrs. Guire Collins  
Address 121 Conduit St. Annapolis Md.  
17. Burial Date thereof Feb 15<sup>th</sup> 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematorium St Mary's  
Location Annapolis Md.

18. Funeral director John M. Lay Jr. Son  
Address Annapolis Md.  
19. Feb 24 48  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1948 at 145 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15, 1948 to Feb. 22, 1948  
and that I last saw her alive on Feb. 22, 1948  
Immediate cause of death Broncho Pneumonia DURATION 12 days  
Due to Fractured Hip, left 1 month  
Due to Hypertensive Cardio-vascular renal disease 15 yrs.  
Other conditions Sensility  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident Date of Jan. 14, 1948  
Accident, suicide, or homicide  
Where did injury occur Annapolis Annapolis Md.  
(City & town) (County) (State)  
Injured at home, farm, industry, pub'c place (where?) Home  
Means of injury Fell in own home Injured at work? No

23. SIGNATURE James R. Martin, M.D. M.D. or other  
Address Annapolis, Md. Date signed 2-22-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 25 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01303

Reg. Dist. No. 22

## 1. PLACE OF DEATH

County Anne ArundelCity or town Darkey  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne ArundelCity or town Darkey  
(If outside city or town limits, write RURAL and give nearest town)Street No. First Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Edgar Raymond Green4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Annie M. Green

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 18888. AGE: Years 59 Months 5 Days 6 If less than one day hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farmer12. Name Israel J. Green13. Birthplace Md.14. Maiden name Laura Williams15. Birthplace Md.16. Informant Mrs. Annie M. GreenAddress Darkey, Md.17. Burial Date thereof Feb. 4, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MeadowridgeLocation Darkey, Md.18. Funeral director W. Witt DavidsonAddress Darkey, Md.19. Feb. 3 19 48 Lura Haskin  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st 19 48 at 9:30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20th 19 48 to Feb. 1st 19 48 and that I last saw him alive on Feb. 1st 19 48Immediate cause of death Coronary thrombosisDURATION 1 hr.Due to Chr. Arterio-sclerosis3 yrs.

Due to

Other conditions ☒

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M.D. M. D. or otherAddress Savage, Md. Date signed 2/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

FEB 26 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Forest Glen - P.O. Pasadena.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 months  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD. County A. A. Co.  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Forest Glen  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Philip - William - Keiffitt

## 3. (b) Social Security Number

## 4. Sex

M.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Single.

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

October - 15 - 1947

## 8. AGE:

Years

Months

Days

If less than one day

— 4 1 hrs. min.

## 9. Birthplace

Wormers Mass. - Baltimore  
(Town, county, and state)

## 10. Usual occupation

None.

## 11. Industry or business

## FATHER

## 12. Name

Harold L. Keiffitt

## 13. Birthplace

Pennsylvania

## MOTHER

## 14. Maiden name

Margaret Salves Tarbutton

## 15. Birthplace

Baltimore, Md.

## 16. Informant

Wm. L. L. Keiffitt (father)

## Address

Forest Glen - P.O. Pasadena, Md.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

2/19/49  
(month) (day) (year)

## Cemetery or crematory

Moreland Memorial

## Location

Baeto; County, Ind.

## 18. Funeral director

Wm. J. Tiekner & Sons Inc.

## Address

North & P. Ave. Balto. Md.

## 19.

(Date rec'd by registrar)

19

48

Am. Public Health  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February - 16 1948 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

Acute Pulmonary  
Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Ernestine H. Paulsen  
Assistant Medical ExaminerAddress Forest Glen - P.O. Pasadena, Md. Date signed 2/16/48



RECEIVED

MAR 16 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

01306

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis, Forest Hills nr Eastport  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 yrs  
Hospital, institution, or street address where death occurred:  
1014 Forest Hills Drive  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town Rurla Eastport, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1014 Forest Hills Drive  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

GRAYCE MYERS HELLER

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Alfred Heller  
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) December 14, 1887

8. AGE: Years 60 Months 2 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation House-wife

11. Industry or business

FATHER 12. Name Meeks

13. Birthplace Maryland

MOTHER 14. Maiden name Sadie Meeks

15. Birthplace Maryland

16. Informant Mr. Dave Myers

Address 1014 Forest Hills Drive, Eastport, Md.

17. Burial Date thereof 2-25-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Anne's Cemetery

Location Annapolis, Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Md.

19. Feb. 25, 1948  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1948, at 3 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10, 1948 to Feb 23, 1948  
and that I last saw her alive on Feb 23, 1948

Immediate cause of death Myocarditis + thrombosis  
insufficiency DURATION 13 days

Due to Arteriosclerosis

Due to Myocarditis

Other conditions Chronic Interstitial Nephritis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

13. SIGNATURE George C. Buel M. D. or other

Address Annapolis Md Date signed 2-24-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01307

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months, 29 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital, Crownsville, Md.  
 How long in hospital or institution? 5 months, 29 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 49 Rogers Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

LULU H. JAMISON

## 3. (b) Social Security Number

\*\*\*\*\*

4. Sex Female 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) unknown 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 65 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Alabama  
 (Town, county, and state)  
 10. Usual occupation Domestic  
 11. Industry or business None  
 12. Name Milborn Bech  
 13. Birthplace unknown  
 14. Maiden name Rebecca Jamison  
 15. Birthplace unknown

16. Informant Hospital Records  
 Address Crownsville, Maryland  
 17. Burial Date thereof 2-22-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Selma Cemetery  
 Location Selma, Alabama  
 18. Funeral director Mrs. Charles E. Hicks  
 Address 43-45 Northwest Street  
 19. Feb. 16 19 48  
 (Date rec'd by registrar) Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13th 19 48 at 8:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 15th 19 47 to February 13 19 48  
 and that I last saw h. er alive on February 13th 19 48

Immediate cause of death Generalized Arteriosclerosis known to us since 8/15/47  
 DURATION

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions Senile Psychosis Known to us since 8/15/47  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

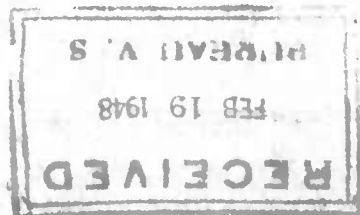
Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_  
 Address Crownsville, Maryland Date signed 2/14/48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01308

## CERTIFICATE OF DEATH

Reg. Dist. No. 2/

## 1. PLACE OF DEATH:

County... Queen Anne'sCity or town... Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

86 Rock Street

How long in hospital or institution?

## 3. (a) FULL NAME

Alexander Johnson

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Gertrude Johnson

7. Birth date of

deceased (mo., day, yr.)

Jan. 11, 1880

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

6824

hrs.

min.

9. Birthplace

Annapolis, A. D. Co., Md.  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

Martin Johnson

13. Birthplace

A. D. Co.

14. Maiden name

Molly Bonds

15. Birthplace

A. D. Co.

16. Informant

Gertrude Johnson

Address

86 Rock St. Annapolis, Md.

17.

Burial

Date thereof

Feb. 7, 1948  
(month) (day) (year)

Cemetery or crematory

Brewer Hill

Location

Annapolis, Md.

18. Funeral director

J. B. Johnson

Address

Annapolis, Md. P. O. Box 462

19.

Feb. 61948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Queen Anne's

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.

86 Rock Street

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

February 4

1948

at

6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 11947

to

Feb 4

1948

and that I last saw him alive on

12-1-47

Immediate cause of death

Heart  
congestive failure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. T. Allen

M. D. or other

Address

17 Carroll

Date signed

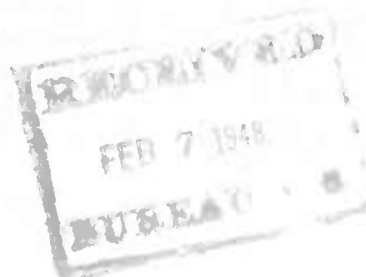
2-5-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01309

21

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Anne Arundel

City or town... Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... C. &amp; C. Co.

City or town... Defense Highway

(If outside city or town limits, write RURAL and give nearest town)

Street No. ... near Ana Road

(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Daniel E. Heller, Sr.

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mary G. Heller

7. Birth date of

deceased (mo., day, yr.)

July 25<sup>th</sup> 1879

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

68

6

9

hrs.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

ret. steamfitter USNA

11. Industry or business

FATHER

12. Name

Daniel E. Heller

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Ernestine Schenck

15. Birthplace

Balls, Md.

16. Informant

Daniel E. Heller, Jr.

Address

Annapolis, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/5/48

(month) (day) (year)

Cemetery or crematory

St. Mary's Cemetery

Location

Annapolis, Md.

18. Funeral director

John M. Taylor, Jr.

Address

Annapolis, Md.

19. Feb. 5

19

48

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 3, 1948, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 15, 1948, to Feb. 2, 1948,

and that I last saw him alive on Feb. 3, 1948.

Immediate cause of death

1. Coronal Occlusion  
2. Cardiac infarction

Due to

Arteriosclerotic-Cardiac  
Vascular disease

Other conditions

DURATION

19.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Albert R. Anderson, M.D.  
Annapolis, Md.

M. D. or other

Address

Date signed

7/4/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 6 1948  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01310

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Best Gate  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town Best Gate  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Kirchner

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Katherine Kirchner

## 6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

January 17<sup>th</sup> 1877

## 8. AGE:

Years

Months

Days

If less than one day

71112

hrs.

min.

## 9. Birthplace

Austria

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

## FATHER

## 12. Name

John Kirchner

## 13. Birthplace

Austria

## MOTHER

## 14. Maiden name

unknown

## 15. Birthplace

unknown

## 16. Informant

Mrs. John Kirchner

## Address

Best Gate - A. A. Co. - Md.

## 17. (Burial, cremation, or removal, Which?)

Burial

## Date thereof

3/3/48

## Cemetery or crematory

St. Mary's Cemetery

## Location

Annapolis, Md.

## 18. Funeral director

John M. Taylor, Jr.

## Address

Annapolis, Md.

## 19. (Date rec'd by registrar)

March 2 19 48

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Feb. 29 19 48 at 7<sup>35</sup> P. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 519 47to Feb. 29 19 48

## and that I last saw him alive on

Feb. 29 19 48

## Immediate cause of death

## DURATION

Carcinoma of Large Intestine. Metastases to liver and adrenal glands.2 years

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

Date of \_\_\_\_\_

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, pub'c place (where?)

## Means of injury

Injured at work?

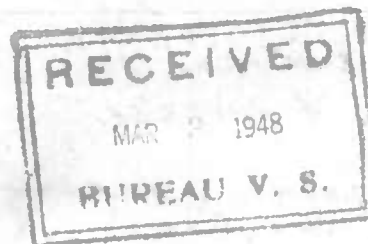
## 23. SIGNATURE

John M. Coffey M.D.

M. D. or other

Address

Annapolis, Md.Date signed 3-1-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Anne Arundel  
 City or town... Dorsey  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 hrs  
 Hospital, institution, or street address where death occurred:  
 Race Road  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md County... Anne Arundel  
 City or town... Dorsey  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Race Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... no

## 3. (a) FULL NAME

Johannah (Schneider) Klamp.

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

8. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Henry J. Klamp

7. Birth date of deceased (mo., day, yr.)

July 4 1998

6. (c) If alive, give age

53 years

8. AGE:

Years	Months	Days	If less than one day
49	7	21	hrs. min.

9. Birthplace

Baltimore City  
(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

Homemaker

MOTHER FATHER

12. Name

William Henry Schneider

13. Birthplace

Baltimore Md

14. Maiden name

Charlotte Shaid

15. Birthplace

Baltimore Md

16. Informant

Mr Henry Klamp Jr

Address

Dorsey Md

17. Burial

(Burial, cremation, or removal, Which?) Date thereof 2-28-48  
(month) (day) (year)

Cemetery or crematory

Meadowridge Memorial Pk

Location

A.A. Co.

18. Funeral director

Charles F. Will

Address

1501 E. Fort Ave

Feb 27 19 48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 19 48 at 11 40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 43 to Feb 25 19 48

and that I last saw him alive on Feb 25 19 48

Immediate cause of death

Dilatation of heart

Due to Myocardial

Due to self sufficiency

Due to arterial Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address... Date signed... 2/26/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01312

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Eastport  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County A. A. Co.City or town Eastport  
(If outside city or town limits, write RURAL and give nearest town)Street No. 426 Burnside Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ANNIE Wiggins Lamb

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Andrew C. Lamb

## 7. Birth date of deceased (mo., day, yr.)

July 13<sup>th</sup> 1865

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

83710

hrs.

min.

## 9. Birthplace

Annapolis, A. A. Co. Md.  
(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business

## FATHER

## 12. Name

Williams, Wiggins

## 13. Birthplace

Annapolis, Md.

## MOTHER

## 14. Maiden name

Margaret Brunel

## 15. Birthplace

Annapolis, Md.

## 16. Informant

Mr. Charles Lamb

## Address

Eastport, Maryland

## 17. Burial

(Burial, cremation, or removal, Which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

St. Ann's Cemetery

## Location

Annapolis, Md.

## 18. Funeral director

## Address

Annapolis, Md.

## 19. Feb 24 48

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 19 48, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 19 48, to Feb 23 19 48  
and that I last saw u alive on Feb 23 19 48

## Immediate cause of death

Myocardial Infarction  
Myocardial Infarction

## Due to

Arteriosclerosis

## Due to

Thrombosis

## Other conditions

Thrombosis  
Arteriosclerosis

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

George C. Basil  
Annapolis, Md.

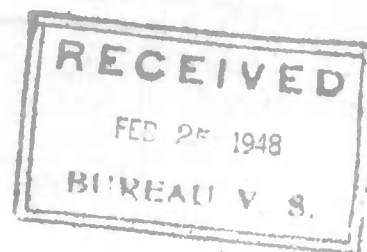
M. D. or other

Date signed 2. 23. 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 31 days  
 Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Annapolis, Md.  
 How long in hospital or institution? 31 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 203 Prince George St.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war Spanish American and WWI.

## 3. (a) FULL NAME

LLOYD, Edward (n)

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Elizabeth R. Lloyd  
 7. Birth date of deceased (mo., day, yr.) 7-20-57 6. (c) If alive, give age ..... years  
 8. AGE: Years 90 Months 5 Days 5 If less than one day ..... hrs. .... min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Retired.  
 11. Industry or business

12. Name Edward Lloyd  
 13. Birthplace Maryland  
 14. Maiden name Mary Howard  
 15. Birthplace Maryland

16. Informant Edward Lloyd  
 Address 203 Prince George St. Annapolis, Md.  
 17. Burial Date thereof July 9, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Naval Academy  
 Location Annapolis, Md.  
 18. Funeral director John M. Taylor, Son  
 Address Annapolis, Md.  
Feb. 8, 1948  
 19. (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5-48 19 48 at 3:57 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-5 19 48 to 2-5 19 48  
 and that I last saw him alive on 2-5 19 48

Immediate cause of death Arteriosclerotic Heart Disease with Left Ventricular Failure.

DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... , Injured at work?

23. SIGNATURE G.M. DAVIS, Commander (MC) USNAddress U.S. Naval Hospital Date signed 5 February 1948Address Annapolis, Maryland

RECEIVED

FEB 12 1948

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01314

1. PLACE OF DEATH: *Brooklyn*  
County *917 Church St*  
City or town *A.A. Co*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State *md* County *A.A. Co*  
City or town *Brooklyn*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *917 Church St*  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME *Demian Lubunyz* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*  
6. (b) Name of husband or wife *Mary* 6. (c) If alive, give age *75* years  
7. Birth date of deceased (mo., day, yr.) *Sept. 4 - 1870*  
8. AGE: Years *77* Months Days If less than one day  
hrs. min.

8. Birthplace *Ukrania*  
(Town, county, and state)  
10. Usual occupation *Retired*  
11. Industry or business  
12. Name *Ignac Lubunyz*  
13. Birthplace *Ukrania*  
14. Maiden name *Jrsenka Lubunyz*  
15. Birthplace *Ukrania*

18. Informant *Mary Lubunyz*  
Address *917 Church St*  
17. *Burial* Date thereof *2-16-48*  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory *Holy Cross*  
Location *A.A. Co*

18. Funeral director *Mr. S. Fialkowski*  
Address *2007 Eastern Ave*  
19. *2/13/48* *A.W. Hedrick*  
(Date rec'd by registrar) (Signature) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 12* 19 *48* at *7:30 A.M.*  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 10* 19 *47*, to *Feb. 12* 19 *48*  
and that I last saw him *alive* on *Feb. 11* 19 *48*  
Immediate cause of death *Colman's Occlusion* DURATION *1 day*  
Due to *Arterio-Sclerotic Cardiovascular Disease*  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
3. SIGNATURE *Paul Lubin* M. D. or other  
Address *320 Indiana Ave* Date signed *2/13/48*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01315

Reg. Dist. No. 28

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 years, 2 months, 8 days  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital, Crownsville, Md.  
How long in hospital or institution? 4 years, 2 months, 8 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Germantown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

SEDONIA MASON

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Jerry Mason (dead)  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) 1877  
8. AGE: Years 70 Months ? Days ? If less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Domestic  
11. Industry or business unknown  
12. Name unknown  
13. Birthplace unknown  
14. Maiden name unknown  
15. Birthplace unknown

16. Informant Hospital Records  
Address Crownsville, Maryland  
17. Burial Buried Date thereof Feb 20 1948  
(Burial, cremation, or other disposal. Which?) (month) (day) (year)  
Cemetery or crematorium Rocky Hill  
Location Montgomery Co  
18. Funeral director Rev. W. Barber  
Address 3/12/48  
19. (Date rec'd by registrar) 3/12/48 Registrar E. J. Joyce Local

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 16th 19 48 at 6:15 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8th 19 43 to February 16 19 48  
and that I last saw her alive on February 16th 19 48  
Immediate cause of death General Paresis Known to us since 12/8/43  
Other conditions General Paresis Known to us since 12/8/43  
(Include pregnancy within 3 months of death)  
Major findings of operations (Include pregnancy within 3 months of death)  
Date of op. (Include pregnancy within 3 months of death)  
Autopsy results (Include pregnancy within 3 months of death)  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

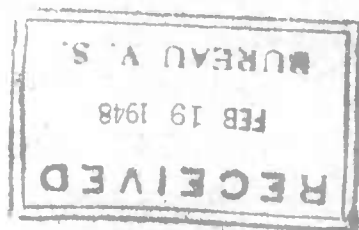
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide (Include pregnancy within 3 months of death) Date of (Include pregnancy within 3 months of death)  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) (Include pregnancy within 3 months of death)  
Means of injury (Include pregnancy within 3 months of death) Injured at work? (Include pregnancy within 3 months of death)  
23. SIGNATURE Joseph H. Hargrave M.D.  
Address Crownsville, Maryland Date signed 2/17/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

01316

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Ad CoCity or town Bar Harbor  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Me County Ad CoCity or town Bar Harbor  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war. ....

## 3. (a) FULL NAME

Wesley S. Mc Clean

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 8. (b) Name of husband or wife

Mary Hoffman

## 7. Birth date of deceased (mo., day, yr.)

October 16, 1877

## 6. (c) If alive, give age. .... years

## 8. AGE:

Years

Months

Days

If less than one day

70

hrs.

min.

## 9. Birthplace

Maryland  
(City, county, and state)

## 10. Usual occupation

Retired Battalion Chief

## 11. Industry or business

Balt City Fire Dept.

## FATHER

## 12. Name

William Mc Clean

## 13. Birthplace

Unknown

## MOTHER

## 14. Maiden name

Mary Dickert

## 15. Birthplace

Unknown

## 16. Informant

Mrs Mary Hoffman

## Address

Bar Harbor Ad Co Md

## 17. Burial

(Burial, cremation, or removal? Which?)

Date thereof

2/1/48  
(month) (day) (year)

## Cemetery or crematory

London Park

## Location

Frederick Rd

## 18. Funeral director

John F. Denny Inc

## Address

7157 Light St.

## 19. (Date rec'd by registrar)

1/14/48

19

1/14/48

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1/14/48

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1/14/48

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1/14/48

19

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1948 at 2:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5, 1948 to Feb. 12, 1948and that I last saw him alive on Feb. 12, 1948Immediate cause of death Heart Failure

## DURATION

Due to Arteriosclerotic lesions 10 yearsDue to Varicella disease 10 yearsDue to Diabetes Mellitus 10 yearsOther conditions Diabetes Mellitus 10 years

(Include pregnancy within 5 months of death)

Major findings of operations. ....

Date of op. ....

Autopsy results. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Brady Smith, M.D. M. D. or otherAddress Riviera Beach Md Date signed 2/12/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

01317

28

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Crownsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? dead on arrivalHospital, institution, or street address where death occurred Crownsville State HospitalHow long in hospital or institution? dead on arrival

## 3. (a) FULL NAME

Linwood M. Daniel, Jr.

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Negro

## 6. (a) Single, married, widowed, or divorced

—

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

July 1, 1944

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

3713

hrs.

min.

## 9. Birthplace

Baltimore City, Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## MOTHER

## 12. Name

Linwood M. Daniel Jr.

## 13. Birthplace

Washington D.C.

## 14. Maiden name

Allice

## 15. Birthplace

Pennsylvania

## 18. Informant

Linwood M. Daniel Sr.

## Address

Crownsville, Md.

## 17. (Burial, cremation, or removal, which?)

Burial

## Date thereof

Feb-17-48

## Cemetery or crematory

Waterbury Cemetery

## Location

Anne Arundel Co. Md.

## 18. Funeral director

Chas. O. Wilson

## Address

1900 Brantley Ave

## 19. (Date rec'd by registrar)

2-12-481948A. W. Hedrick

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Crownsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Waterbury  
(If rural, give LOCATION)

## 2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Feb. 14 1948 at 4:50 P. M.21. I CERTIFY that death occurred on the date above stated, in a Postmortem Examinationand that I last saw it alive Feb. 14 1948

## Immediate cause of death

Drowning

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2-14-48Where did injury occur? Waterbury H.A. Maryland  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury fell face downward in puddle of water

## 23. SIGNATURE

John M. Leffle MDM. D. or EXAMINERAddress Annapolis Md. Date signed 2-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01318 27

## 1. PLACE OF DEATH:

County... Anne Arundel  
 City or town... Fort George G Meade  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 1 yr 2 mos  
 Hospital, institution, or street address where death occurred:  
NC-113  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Anne Arundel  
 City or town... Fort George G Meade  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... NC-113  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

CARROLL EUGENE MESSER

## 3. (b) Social Security Number

4. Sex... Male  
 5. Color or race... White  
 6.(a) Single, married, widowed, or divorced... Single

6.(b) Name of husband or wife...  
 6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)... 21 December 1944

8. AGE: Years Months Days If less than one day  
3 2 5 ...hrs. ...min.

9. Birthplace... Sturgis South Dakota  
 (Town, county, and state)

10. Usual occupation...

11. Industry or business...

12. Name... M/Sgt. Eugene Messer  
 13. Birthplace... Clay Co. Alabama

14. Maiden name... Loretta H. Meyer  
 15. Birthplace... Meade Co., South Dakota

16. Informant... M/Sgt. Eugene Messer  
 Address... 3rd Cav., Ft. Geo. G. Meade, Md

17. Burial Date thereof... 28 February 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Post

Location... Fort George G Meade

18. Funeral director... Lilly & Zeiler Inc  
 Address... 403 S. Wolfe St., Balto., Md.

19. 27 Feb is 48 James H. Gougeon  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 26 February 19 48 at 1600 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 and that I last saw him alive on  
 Immediate cause of death... Encephalitis, chronic  
 DURATION... 3 yrs

Due to...  
 Due to...  
 Other conditions...  
 (Include pregnancy within 3 months of death)

Major findings of operations...  
 Date of op...

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... Henry M. Foster  
 HENRY M. FOSTER 1st Lt M. D. or other  
 Address... Sta Hosp Ft. Geo. G. Meade Date signed... 27 Feb. 48

RECEIVED

FEB 28 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 100

### 1. PLACE OF DEATH:

County 7 Anne Arundel  
City or town Crownsville Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 12 days.  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital Crownsville, Md.  
How long in hospital or institution? 12/ days.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles  
City or town Marbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_ ✓

### 3. (a) FULL NAME

Mary Montgomery

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife ? 6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Mo. and day not known Yr. 1922  
8. AGE: Years 26 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business \_\_\_\_\_

12. Name John J. Montgomery

13. Birthplace Marbury, Md.

14. Maiden name Rosie Dyssen

15. Birthplace St. Margarets, Md.

16. Informant Hospital Records

Address Crownsville, Maryland

17. Burial Date thereof Feb 9, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory cemetery

Location \_\_\_\_\_

18. Funeral director Hunt & Ryan

Address Waldorf, Maryland

19. 2-9 19 48  
(Date rec'd by registrar)

Registrar John H. Pares

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1948 at 12:45a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27, 1948 to February 7, 1948

and that I last saw her alive on February 7, 1948

Immediate cause of death Exhaustion Delirium

DURATION

4 days

Due to Catatonic excitment known to \_\_\_\_\_

us since 1/27/48

Due to \_\_\_\_\_ known to \_\_\_\_\_

Other conditions Schizophrenia catatonic us since 1/27/48

type. \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John Montgomery M.D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



*Hunt & Rogers*  
*per E. Rogers M.D.*



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 013220

1. PLACE OF DEATH: *Home Apartment*  
 County *Prince Georges*  
 City or town *Quantico*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *3 years*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *MD* County *A.A.*  
 City or town *Quantico*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.   
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME *Betty Chester Murray*

3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Married*  
 6. (b) Name of husband or wife *Robert D. Murray*  
 6. (c) If alive, give age *85* years  
 7. Birth date of deceased (mo., day, yr.) *7 March 1865*

8. AGE: Years *82* Months *11* Days *22* It less than one day  hrs.  min.

9. Birthplace *Philadelphia*  
 (Town, county, and state)

10. Usual occupation *Home keeper*

11. Industry or business *None*

12. Name *Robert D. Murray*

13. Birthplace *Elk Ridge Md*

14. Maiden name *Mary D. Morris*

15. Birthplace *Philadelphia Pa.*

16. Informant *Forbes Calhoun*

Address *Quantico Md.*

17. *Funeral* Date thereof *Mar 1 - 1948*  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory *First Church*  
 Location *Quantico Md*

18. Funeral director *J. B. Borden & Son*  
 Address *Quantico Md*

19. *3/11/48* (Date rec'd by registrar)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH *Feb 29* 19 *48* at *2:45 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan* 19 *45*, to *Feb 29* 19 *48*  
 and that I last saw him alive on *Feb 29* 19 *48*

Immediate cause of death *acute pneumonia (terminal)*

Due to

Due to

Other conditions *arteriosclerosis - cardio*  
*vascul disease*  
 (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE *J. B. Borden*

Address *Quantico Md* Date signed *2/11/48*

Address  Date signed

Address  Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 3 1948

BUREAU Y S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01321

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

16 Franklin Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County A. A. CoCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 16 Franklin St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Frances Hallyday Norris

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Walter B Norris

7. Birth date of deceased (mo., day, yr.)

December 10<sup>th</sup> 1874

6. (c) If alive, give age years

8. AGE:

Years 73Months 1Days 25

If less than one day

hrs.

min.

9. Birthplace

Easton Md.  
(Town/county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Frances Hallyday

13. Birthplace

Maryland

14. Maiden name

Sarah Hugglett

15. Birthplace

Maryland

16. Informant

Walter B Norris

Address

Annapolis, Md.

17.

Burial  
(Burial, cremation, or removal, Which?)

Date thereof

2/7/48  
(month) (day) (year)

Cemetery or crematory

St. Ann's Cemetery

Location

Annapolis Md.

18. Funeral director

Address

John W. Taylor, Jr.  
Annapolis Md.

19.

Feb. 7 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4<sup>th</sup> 1948 at 9:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4 1948 to Feb 4 1948  
and that I last saw her alive on Feb 4 1948

Immediate cause of death

Cardio-Vascular Failure

Due to

Acute Congestive Heart Failure

Due to

Cr. Myocarditis

Other condition

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

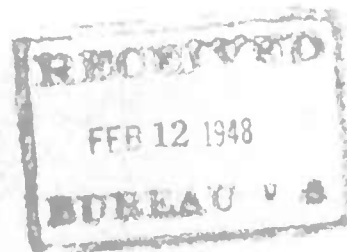
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Oliver Purvis  
Annapolis Md Date signed 2/5/48

M. D. or other



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01322

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel  
 County.....Annapolis  
 City or town.....Life  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
32 Pleasant Street  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Maryland County.....Anne Arundel  
 City or town.....Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....32 Pleasant Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
Zebidee Parker

3. (b) Social Security Number  
None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife.....Charity Parker

7. Birth date of deceased (mo., day, yr.) June 27, 1864 6. (c) If alive, give age..... years

8. AGE: Years 83 Months 7 Days 17 If less than one day..... hrs. .... min.

9. Birthplace.....Annapolis, Anne Arundel Co. Md.  
 (Town, county, and state)

10. Usual occupation.....Laborer

11. Industry or business None

12. Name.....Charles Parker

13. Birthplace.....Anne Arundel Co. Md.

14. Maiden name.....Eliza Queen

15. Birthplace.....Anne Arundel Co. Md.

16. Informant.....Charity Parker

Address.....32 Pleasant Street

17. Burial Date thereof.....2-17-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Brewer Hill

Location.....West Street Extended

18. Funeral director.....Mrs. Charles L. Hicks

Address.....43-45 Northwest Street

19. Feb. 16 19 48  
 (Date rec'd by registrar) Registrar [Signature]

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 13 19 48 at 3:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-2 19 48 to 2-14 19 48 and that I last saw him alive on 2-11- 19 48

Immediate cause of death.....Cerebro-vascular accident.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....[Signature] M. D. or other

Address.....17 Carroll Date signed.....2-14-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



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FEB 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

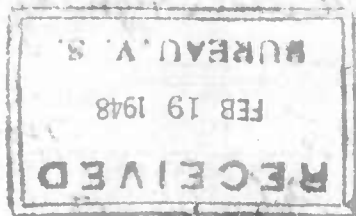
2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01324

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b> County <u>Anne Arundel</u> City or town <u>Civil Station</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>4 years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Md.</u> County <u>Anne Arundel</u> City or town <u>Civil Station</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>General Highway Route 178</u> (If rural, give LOCATION) 2.(d) If veteran, name war	
<b>3. (a) FULL NAME</b> <u>Emma S. Reber</u>		<b>3. (b) Social Security Number</b> <u>None</u>	
<b>4. Sex</b> <u>Fi.</u>	<b>5. Color or race</b> <u>W.</u>	<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>	
<b>6. (b) Name of husband or wife</b> <u>Thomas J. Reber</u>		<b>6. (c) If alive, give age</b> _____ years	
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>March 27 - 1862</u>			
<b>8. AGE:</b> Years <u>85</u> Months <u>10</u> Days <u>21</u> If less than one day _____ hrs. _____ min.			
<b>9. Birthplace</b> <u>W. Va.</u> (Town, county, and state)			
<b>10. Usual occupation</b> <u>at home</u>			
<b>11. Industry or business</b>			
<b>FATHER</b> 12. Name <u>Otho Marshall</u> 13. Birthplace <u>W. Va.</u>			
<b>MOTHER</b> 14. Maiden name <u>Eliza Buckmaster</u> 15. Birthplace <u>W. Va.</u>			
<b>16. Informant</b> <u>Mrs. Stella M. North</u> Address <u>Rt. 1 #1 Box 147 Annapolis Md</u> <u>Feb 18 1948</u>			
<b>17. Burial</b> (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year) <u>Feb 18 1948</u> Cemetery or crematory <u>London Park</u> Location <u>Baltimore, Md</u> <b>18. Funeral director</b> <u>J. Howard Strong</u> Address <u>3707 N. ...</u>			
<b>19. Feb. 18, 1948</b> (Date rec'd by registrar) Registrar <u>[Signature]</u>			
<b>MEDICAL CERTIFICATION</b>			
<b>20. DATE OF DEATH</b> <u>February 17, 1948</u>			
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Apr. 21, 1944</u> to <u>Feb. 17, 1948</u> and that I last saw him alive on <u>Feb. 16, 1948</u>			
<b>Immediate cause of death</b> <u>Carcinoma of head of pancreas</u>			<b>DURATION</b> <u>6-8 mos.</u>
<b>Due to</b>			<b>15 yrs.</b>
<b>Other conditions</b> <u>hypertensive cardio-vascular disease</u> (Include pregnancy within 3 months of death)			
<b>Major findings of operations</b>			
<b>Autopsy results</b>			
<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____			
<b>23. SIGNATURE</b> <u>A. Borman</u> M. D. or other Address <u>Annapolis Md</u> Date signed <u>2/18/48</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01325

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital, Crownsville, Md.  
 How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 611 Brume  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOSHUA SIMMS

## 3. (b) Social Security Number

217-01-5776

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Estelle Simms  
 7. Birth date of deceased (mo., day, yr.) October 23, 1892 6. (c) If alive, give age 2 years  
 8. AGE: Years 55 Months 3 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name Jim Simms  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Edmona Botley  
 15. Birthplace Maryland

16. Informant Hospital Records  
 Address Crownsville, Maryland  
 17. Burial Arbutus Mem'l. Pk. Date thereof 2/18/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Balto. County, Md  
 Location \_\_\_\_\_

18. Funeral director Charles G. Cooper  
 Address 510-12 N. Carrollton Ave  
 19. 2/18 19 48 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 11th 19 48 at 8:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 26th 19 48 to February 11th 19 48  
 and that I last saw him alive on February 11th 19 48

Immediate cause of death Myocarditis Degeneration Known to us since 1/26/48  
 DURATION

Due to \_\_\_\_\_  
 Due to General Paresis Known to us since 1/26/48  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Jacob H. Henshaw M.D.  
 Address Crownsville, Maryland Date signed 2/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5707 Johnson St

How long in hospital or institution?

## 3. (a) FULL NAME

Clara M. Simon

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Fredrick7. Birth date of deceased (mo., day, yr.) Feb 27, 19048. AGE: Years 43 Months 11 Days 1 If less than one day9. Birthplace Fort Wayne Ind  
(Town, county and state)10. Usual occupation Housewife

11. Industry or business

12. Name William A. Bonde13. Birthplace Indiana14. Maiden name Caroline R. Bonfelle15. Birthplace Indiana16. Informant Fredrick SimonAddress 5707 Johnson St A.C.C. Md(Burial, cremation or removal. Which?) Date thereof 2/1/48  
(month) (day) (year)Cemetery or crematory Oak HillLocation Baltimore18. Funeral director William R. JonesAddress 1217 1st Ave19. 2/6 48 S.W. Hedrick  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For persons other than infants give residence of mother)

State Md County Anne ArundelCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5707 Johnson St  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 19 48 at 6 '54 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 19 48 to Feb 4 19 48 and that I last saw him alive on Feb 3 19 48Immediate cause of death coronary occlusionDue to hypertensive Cardi  
Vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Kristin MD M. D. or otherAddress 302 Patapsco Cw Date signed Feb 5 '48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

01327

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

65118

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Feb. 13

(Date rec'd by registrar)

19

48

Date thereof

(month) (day) (year)

Cedar BluffAnnapolis Md.John M. Taylor, SonAnnapolis Md.Wm. J. French

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Eastport  
(If outside city or town limits, write RURAL and give nearest town)Street No. 461 First St  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11<sup>th</sup> 19 48 at 8:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 16 19 46 to Feb 11<sup>th</sup> 19 48and that I last saw her alive on Feb. 11<sup>th</sup> 19 48

Immediate cause of death

Hypertensive Cardiovascular disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

SIGNATURE

M. D. or other

Address

Date signed 2/12/48

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FEB 14 1948

BUREAU



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 93d 01328  
 Village or City Bacon's Near Laurel No. 22 St. 22 Ward 22  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

## 2. FULL NAME

Daisy Thomas If U. S. Veteran, specify WAR \_\_\_\_\_  
 (a) Residence: No. R. F. O. St.        Ward.         
 (Usual place of abode) If nonresident give city or town and State \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single Divorced</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Dane Thomas</u>		
6. DATE OF BIRTH (month, day, and year) <u>Unknown 1889</u>		
7. AGE <u>61</u>	Years <u>61</u>	Months <u>      </u>
	Days <u>      </u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>House Keeper</u>	
	10. Date deceased last worked at this occupation (month and year) _____	
	11. Total time (years) spent in this occupation _____	

12. BIRTHPLACE (city or town) Anne Arundel Co.  
 (State or country) md

FATHER 13. NAME Daniel Thomas

14. BIRTHPLACE (city or town) Anne Arundel Co.  
 (State or country) md

MOTHER 15. MAIDEN NAME Jennie Thomas

16. BIRTHPLACE (city or town) Anne Arundel Co.  
 (State or country) md

17. INFORMANT Egna Springfield  
 (Address) Laurel R. F. O.

18. BURIAL, CREMATION, OR REMOVAL  
 Place Bacon's Date Feb. 27, 1948

19. UNDERTAKER Ridgely Selby  
 (Address) 401 Wash. Ave. Laurel Md.

20. FILED July 27, 1948 Clara Kasper  
 Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

February 25, 1948  
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from February 16, 1947 to February 23, 1948

I last saw him alive on February 23, 1948; death is said to have occurred on the date stated above, at 4:00 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Hypertension Cardiac - vascular disease  
High hemoglobin falling  
Chloral Hydrate  
 Date of onset 1938  
1948

Other Contributory Causes of Importance:

Chronic myocarditis 1938

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)  
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury \_\_\_\_\_

Nature of Injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) John W. Kasper M. D.

(Address) Laurel, Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

**Example II**

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01324

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Salesville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For born infants, give residence of mother)

State Maryland County Anne ArundelCity or town Salesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

Frank Lester Trott

## 3. (b) Social Security Number

132-13-9537

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widower

## 6. (b) Name of husband or wife

B. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

April 16 1894

## 8. AGE:

Years

Months

Days

If less than one day

631017

hrs.

min.

## 9. Birthplace

Baltimore Maryland  
(Town, county, and state)

## 10. Usual occupation

Waterman

## 11. Industry or business

Oysters & Fish

## MOTHER FATHER

## 12. Name

Joseph Trott

## 13. Birthplace

Baltimore, Maryland

## 14. Maiden name

unknown

## 15. Birthplace

Bell D. Trott

## 16. Informant

Address

Annapolis Md

## 17. (Burial, cremation, or removal, which?)

Burial

Date thereof

Mar 1, 1948  
(month) (day) (year)

## Cemetery or crematory

Shelby

## Location

dipl

## 18. Funeral director

W. S. Standish & Son

## Address

Salesville, Md

## 19. (Date rec'd by registrar)

3/1 48Dr. J. H. Trott  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 28 1948 at 7:30 P.M.

## 21. I CERTIFY that death occurred on the date above stated, and that death was due to:

Postmortem Examination

## Immediate cause of death

acute dilatation of heartDue to edema of lungsDue to arterio-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

Signature John M. Coffey M.D.

M. D. or other

Address Annapolis, Md Date signed 2-28-48

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MAR 3 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01330

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? one day  
 Hospital, institution, or street address where death occurred:  
Emergency Hospital  
 How long in hospital or institution? one day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Anne Arundel  
 City or town Gambrills  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Gambrills, Post Office  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war W.W. I

## 3. (a) FULL NAME

RUSSELL C. TURNER SR.

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Evelyn S. Turner  
 6.(c) If alive, give age 50 years  
 7. Birth date of deceased (mo., day, yr.) February 8, 1897  
 8. AGE: Years 51 Months 0 Days 7 If less than one day hrs. min.

9. Birthplace Washington D.C.  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Farming  
 12. Name Zachariah Turner  
 13. Birthplace Maryland  
 14. Maiden name Ella C. Hardy  
 15. Birthplace Maryland

16. Informant Mrs Evelyn S. Turner  
 Address Gambrills, Post Office, A.A. Co. Md.  
 17. Burial Date thereof 2-18-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory St Stephens  
 Location Chesterfield, A.A. Co. Maryland  
 18. Funeral director Ben L. Hopping and Son  
 Address 170-172 West St. Annapolis, Md.

19. Feb 18 19 48  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1948 at 11:15pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 14 19 48 to Feb 15 19 48  
 and that I last saw him alive on Feb. 15 19 48

Immediate cause of death Cerebral hemorrhage DURATION 1 day  
 Due to General Arterio-sclerosis 8 years  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

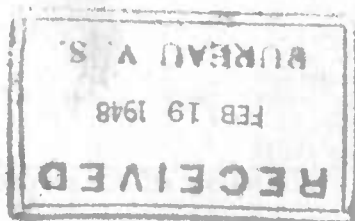
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE John M. Coffey M.D. M. D. or other  
Armadillo Md. Date signed 2-17-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 27

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Fort George G. Meade  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 1/2 - 4 months  
 Hospital, institution, or street address where death occurred:  
Union Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County A.A.  
 City or town Odenton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2444 Chapel Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Robert L. Whitney Jr.

## 3. (b) Social Security Number

## 4. Sex

M.

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

None

## 6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

March - 11 - 1943

## 8. AGE:

Years

Months

Days

If less than one day

4

10

29

hrs.

min.

## 9. Birthplace

Dallas, Texas

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

## FATHER

## 12. Name

Robert L. Whitney Jr.

## 13. Birthplace

Omaha, Nebraska

## MOTHER

## 14. Maiden name

Willie W. Pinner

## 15. Birthplace

Missouri

## 16. Informant

Robert L. Whitney Jr.

## Address

Fort George Meade, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

17 Feb 48

(month) (day) (year)

Cemetery or crematory

Post

## Location

Fort George G Meade

## 18. Funeral director

Lily &amp; Zeiler Inc

## Address

403 S Wolfe St., Balto, Md

## 19. 11 Feb

(Date rec'd by registrar)

19 48

James H. Gougeon

JAMES H. GOUGEON

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 19 48 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Statice Thymus  
Lymphadenitis

Due to

Due to Ameloid - ether

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Tonsillectomy  
and adenectomyDate of op. 2/10/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2/10/48Where did injury occur? Fort George Meade, A.A. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

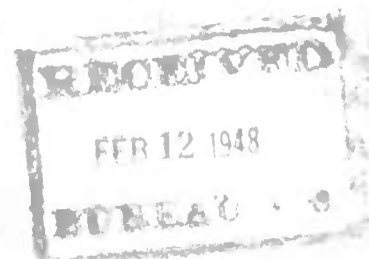
Gustave H. Pauley  
Address Shen Burnie Road Date signed 2/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01332

21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

91 Calvert Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Anne ArundelCity or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 91 Calvert Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Annie Williams

## 3.(b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Colored

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Charles T. Williams

## 7. Birth date of deceased (mo., day, yr.)

August 1907

## 6.(c) If alive, give age.....years

## 8. AGE:

Years

40

Months

5

Days

If less than one day

hrs.

min.

## 9. Birthplace

Unknown

(Town, county, and state)

## 10. Usual occupation

Domestic

## 11. Industry or business

Unknown

## MOTHER FATHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

Charles T. Williams

## Address

91 Calvert St. Annapolis, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 5, 1948

(month) (day) (year)

## Cemetery or crematory

Broadneck

## Location

Skidmore, Md.

## 18. Funeral director

J.B. Johnson

## Address

Annapolis, Md. P.O. Box 462

## 19. Feb 5 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH February 2, 1948 at 9:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 29<sup>th</sup> 1948 to Feb 2<sup>nd</sup> 1948 and that I last saw him alive on Feb 2<sup>nd</sup> 1948

## Immediate cause of death

cerebral hemorrhage

## DURATION

2 years

## Due to

hypertension

## Due to

generalized edema + ascites

## Other conditions

coronary failure

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Edith Pooler MD

M. D. or other

Address

42 State Circle, AnnapolisDate signed 2-4-48

RECEIVED  
FEB 6 1948  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01333

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County... Anne Arundel  
City or town... Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
805 West St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel

City or town... Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 805 West St.  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

John C. Williams

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Isabel H. Williams

## 6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

June 14<sup>th</sup> 1866

## 8. AGE:

Years

Months

Days

If less than one day

81

7

29

hrs.

min.

## 9. Birthplace

Philadelphia, Penn.  
(Town, county, and state)

## 10. Usual occupation

Landing agent for

## 11. Industry or business

Hamburg Line

## FATHER

## 12. Name

Hector C. Williams

## 13. Birthplace

Wales, British Isles

## MOTHER

## 14. Maiden name

Juliana Davis

## 15. Birthplace

Wales, British Isles

## 16. Informant

Mrs. Isabel W. Jackson

## Address

Annapolis, Md.

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

2/14/48  
(month) (day) (year)

## Cemetery or crematory

## Location

Philadelphia, Pa.

## 18. Funeral director

## Address

John M. Taylor, Jr.  
Annapolis, Md.

## 19. Date rec'd by registrar

Feb. 14 1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 13 1946 to Dec. 19 48

and that I last saw him alive on Dec. 13 1948

Immediate cause of death cerebral

hemorrhage

## DURATION

2 days

Due to arterio-sclerotic

cardio-vascular disease

Due to 15 yrs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Brown, M.D.

M. D. or other

Address Annapolis Md. Date signed 2/16/48

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 01334  
 Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital, Crownsville, Md.  
 How long in hospital or institution? 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 304 N. Gilmore  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOSEPH W. WILLIAMS

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Unknown to us Dec. 29, 1897 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 50 Months 2x Days 6x If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name George Williams13. Birthplace unknown14. Maiden name Molly15. Birthplace unknown16. Informant Hospital RecordsAddress Crownsville, Maryland

17. Burial Date thereof Feb 10, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory National CemeteryLocation Bethesda, Md.18. Funeral director Mrs. Katie B. WilliamsAddress 322 N. Schroeder StDate signed by registrar 2/9/48 C. W. Hedrick

19. (Date signed by registrar) \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5th 1948 at 8:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 23rd 1948 to February 5 1948

and that I last saw him alive on February 5th 1948

Immediate cause of death General Paresis Known to us since 1/23/48  
 DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Jacob Hargarten M. D. or otherAddress Crownsville, Maryland Date signed 2/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01335

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 years, 9 months, 6 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital, Crownsville, Md.  
 How long in hospital or institution? 8 years, 9 months, 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 416 N. Parrish  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ROSCOE WOODSON

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) 11/12/1906 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 41 Months 1 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business \_\_\_\_\_  
 12. Name Thomas Walker  
 13. Birthplace Virginia  
 14. Maiden name Eva Wilson  
 15. Birthplace Virginia

16. Informant Hospital Records  
 Address Crownsville, Maryland  
 17. Burial Date thereof Feb. 11, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Auburn  
 Location Mt. Wiggins Rd.  
 18. Funeral director Mrs. Kate R. Williams  
 Address 322 N. Schroeder St.  
 19. 2/4/48 19 \_\_\_\_\_  
 (Date seen by registrar) Registrar A. W. Hedrick

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 7th 19 48 at 1:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 19 41 to February 7 19 48  
 and that I last saw him alive on February 7th 19 48

Immediate cause of death Malignant Hypertension DURATION 3 weeks

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Mental Deficiency Without  
Psychosis Known to \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ us since 5/1/39  
 Date of op. 1939

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Joseph H. Hays M. D. or other \_\_\_\_\_  
 Address Crownsville, Maryland Date signed 2/7/48